

CERTIFICATE OF DEATH

00551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>---</u> Last <u>Adkins</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Janice Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Eastern Shore State Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gangrene, right foot</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 days</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-22-</u> , 19 <u>57</u> , to <u>1-6-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-6-</u> , 19 <u>59</u> , and that death occurred at <u>11:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Currier</u> M.D.		ADDRESS (Street, city or town, state) <u>Rt. 2, Cambridge, Maryland</u>	
DATE SIGNED <u>1-7-59</u>			
PHYSICIAN'S NAME (Type) <u>George E. Currier, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 9 / 59</u>	<u>Baptist Cemetery</u>	<u>Girdletree, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Norman E. Currier, Jr.</u>		DATE <u>JAN 9 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
<u>111 Hill St.</u>		<u>Carlton S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

558 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) Cambridge Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva Minnie Wright		4. DATE OF DEATH Month Jan Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-52
9. AGE (In years last birthday) 96 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Librarian	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rev. N. S. Blogg		14. MOTHER'S MAIDEN NAME Charlotte Thayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Terry Burger		Address 116 E. Melrose Ave Balto. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Corebral Accident with left hemiplegia DUE TO renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardio vascular DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 year + 1 year +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. -- -- -- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --	20f. (City or town) (County) (State) -- -- --
21. I certify that I attended the deceased from 12-8-58 , 19__, to 1-29-59 , 19__, that I last saw the deceased alive on 1-29-59 , 19__, and that death occurred at 1:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) DATE SIGNED 15 Locust Street, Cambridge, Md. 1-29-59	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/31/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Measor		24a. REC'D BY REGISTRAR Jan 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN Life Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia R Egbert		4. DATE OF DEATH Month Jan Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 2, 1919
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter R. Egbert		14. MOTHER'S MAIDEN NAME Beatrice Slimmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Raymond Egbert		Address Baltimore Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) Dr. John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/22/59	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Jan 22, 1959	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home		ADDRESS Cambridge Maryland.	
24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL COLLEGE OF VIRGINIA, DEPARTMENT OF HEALTH-BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00554

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. c. LENGTH OF STAY IN 1b 50 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 21 Cross St.		d. STREET ADDRESS 21 Cross St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virgie Mosars Ennals		4. DATE OF DEATH Jan. 31 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years, last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Mosers		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-4085	
17. INFORMANT Mrs. Lee Roberts		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 2/3/59	
22a. BURIAL, CREMATION, (REMOVAL) (Specify) Feb. 3, 59		22b. DATE THEREOF Feb. 3, 59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's W. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon W. Henry		24a. REC'D BY REGISTRAR FEB 5 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard		24c. ADDRESS Cambridge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME
RESIDENCE
DATE

AGE
SEX
OCCUPATION

EDUCATION
RELIGION
MARRIAGE

CHILDREN
SIBLINGS
PARENTS

ANCESTRY
ETHNICITY
LANGUAGE

RELIGIOUS BELIEFS
POLITICAL AFFILIATION
SOCIAL STATUS

PERSONAL HISTORY
MEDICAL HISTORY
PSYCHOLOGICAL HISTORY

PHYSICAL EXAMINATION
VITAL SIGNS
LABORATORY TESTS

DIAGNOSIS
TREATMENT
PROGNOSIS

REMARKS
SIGNATURE
DATE

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1910

Blank form area for recording patient information and medical history.

561 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN TB <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Madison</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Benjamin</u> Last <u>Fitznaugh</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 3, 1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer in Saw Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Madison</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John R. Fitzhugh</u>				14. MOTHER'S MAIDEN NAME <u>Clementine Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-0645</u>		17. INFORMANT <u>Family Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC GANGRENE LEFT LEG</u> <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>26 day</u> <u>UNDET.</u> <u>UNDET.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 12, 1958</u> to <u>JAN 10, 1959</u> , that I last saw the deceased alive on <u>JAN 10, 1959</u> , and that death occurred at <u>10.20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 RACE ST</u> DATE SIGNED <u>1/12/59</u>							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.				PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV, M.D.</u> <u>CAMBRIDGE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Joppa Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>K. R. Thomas Funr.</u> <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

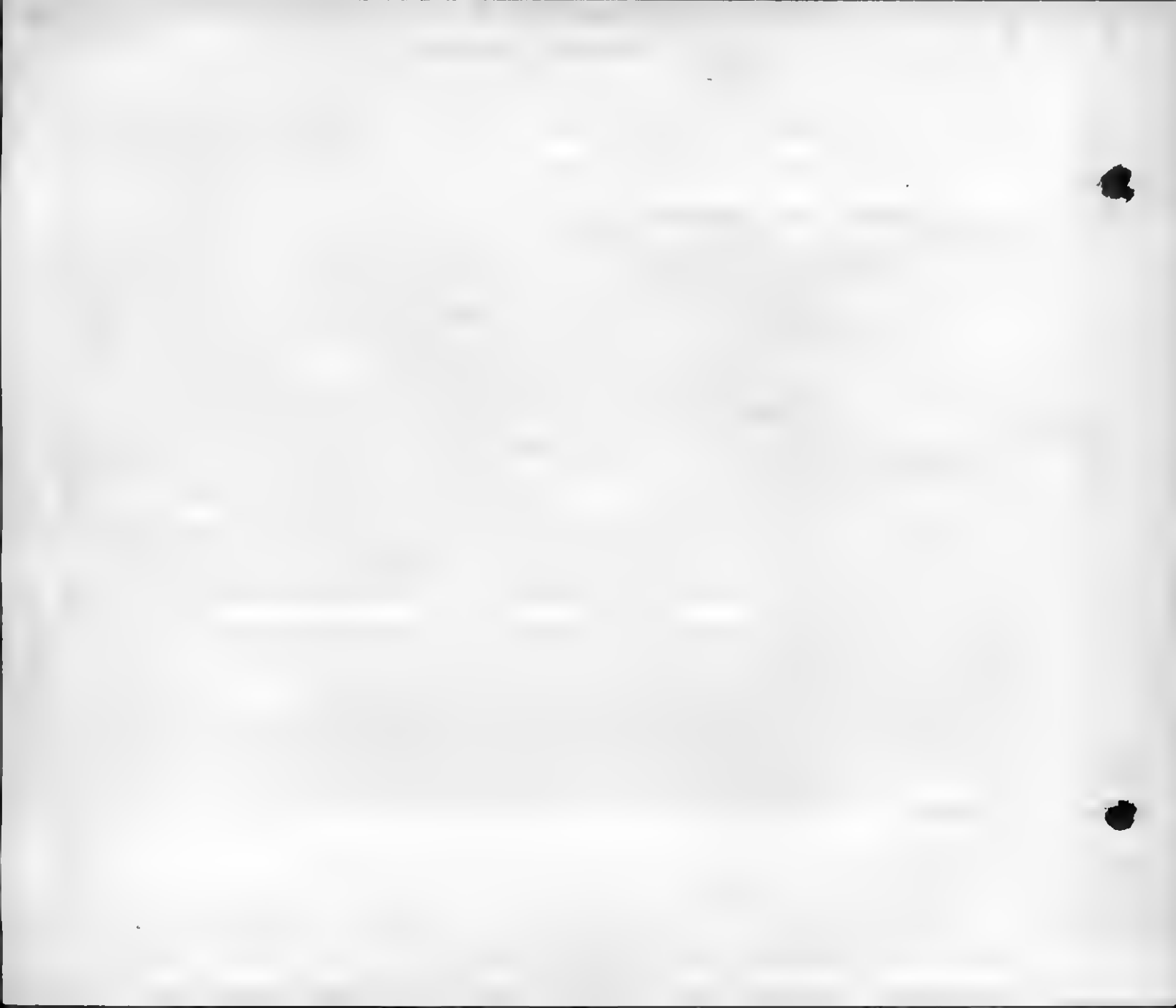
575

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaside</u>		c. LENGTH OF STAY IN TB <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Nursing Home</u>		e. d. STREET ADDRESS <u>East 14th Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jane's Luke Hochett</u>		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CEN. OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Robert Hochett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hochett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Hochett</u>		Address <u>14th Street, Baltimore, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> <u>12 yrs</u> <u>12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Port wine stain</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>10</u> Day <u>12</u> Year <u>1958</u> Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>58</u> , to <u>1/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>59</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jane B. Plummer</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 158 Pileston Md</u> DATE SIGNED <u>1/16/59</u>	
PHYSICIAN'S NAME (Type) <u>Horace B. Plummer</u>		<u>Pileston Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>1/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Hill Market</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Hargrave</u> ADDRESS <u>14th Street</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Walter S. Hargrave</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

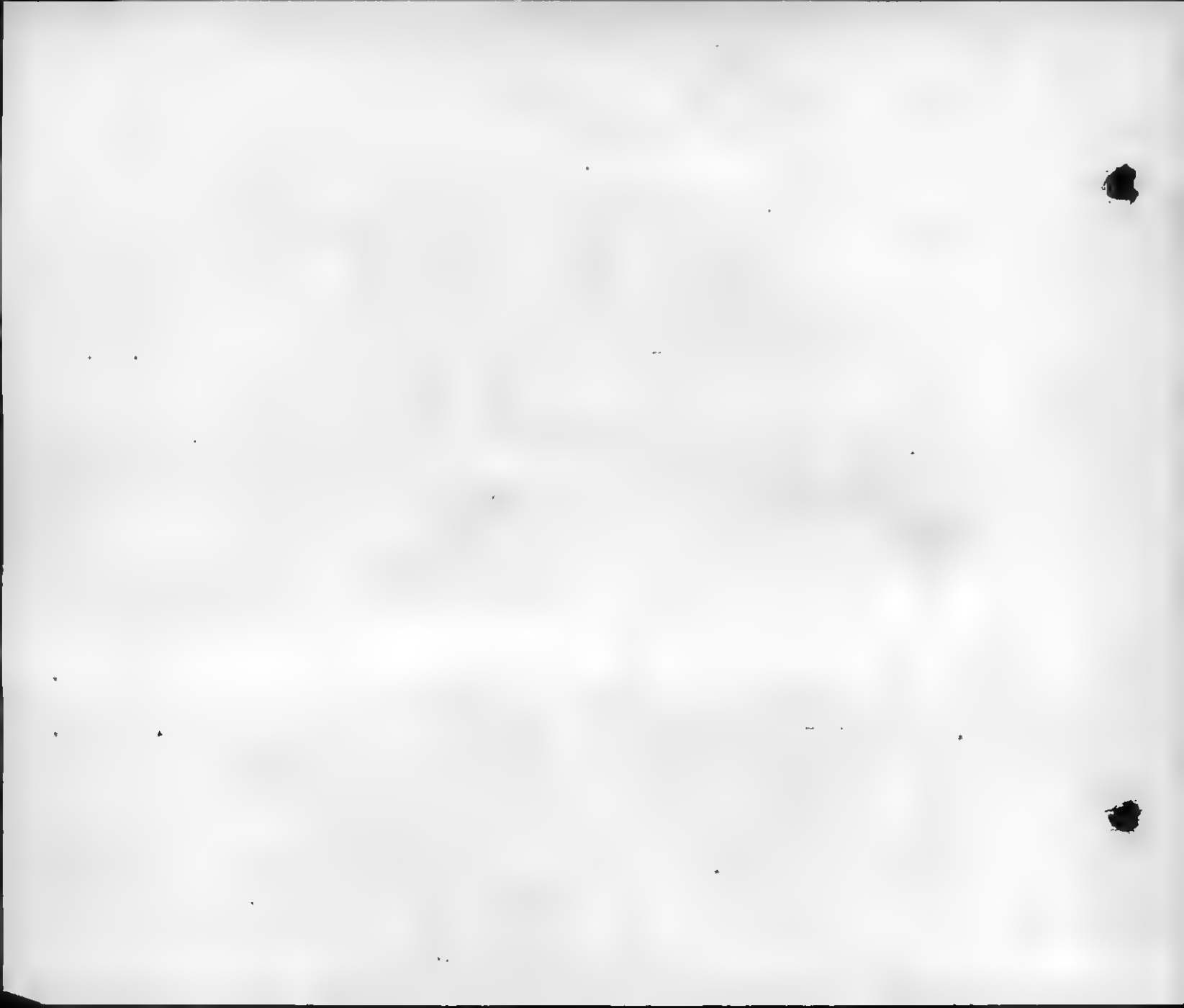
Reg. Dist. No.

576

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>19yr. 7mo. 1da.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Square</u> <u>19x</u>	
		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) <u>Roxie</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Briddell</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unkn.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>RECORDS-</u>		Address <u>Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>904.7</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Fracture neck right femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Found complaining of pain and unable to bear weight on leg.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30 AM</u> a. m. <u>12-29-</u> c. 19 <u>59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Cambridge Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rehoboth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rehoboth Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradley</u>		24a. REC'D BY REGISTRAR <u>Chas. L. Kline</u>	
ADDRESS <u>Chesfield Md</u>		DATE <u>JAN 19 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



377
CERTIFICATE OF DEATH

Reg. Dist. No.

00558

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Glen</u> Last <u>Holmes</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-18</u>	9. AGE (In years last birthday) <u>80 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Worker Ret. Ex. Telephone Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ma</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM F. HOLMES</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH A. HOLSEMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>✓</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-11</u> , 1958, to <u>1-16</u> , 1959, that I last saw the deceased alive on <u>1-16</u> , 1959, and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.H. Cambridge Md 1-16-59</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u> <u>Eastern Shore State Hospital, Cambridge, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-20-59</u>		<u>Catholic Cem.</u>		<u>Calto Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Shelley J. Hume - Cambridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clay E. Kaut</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 238

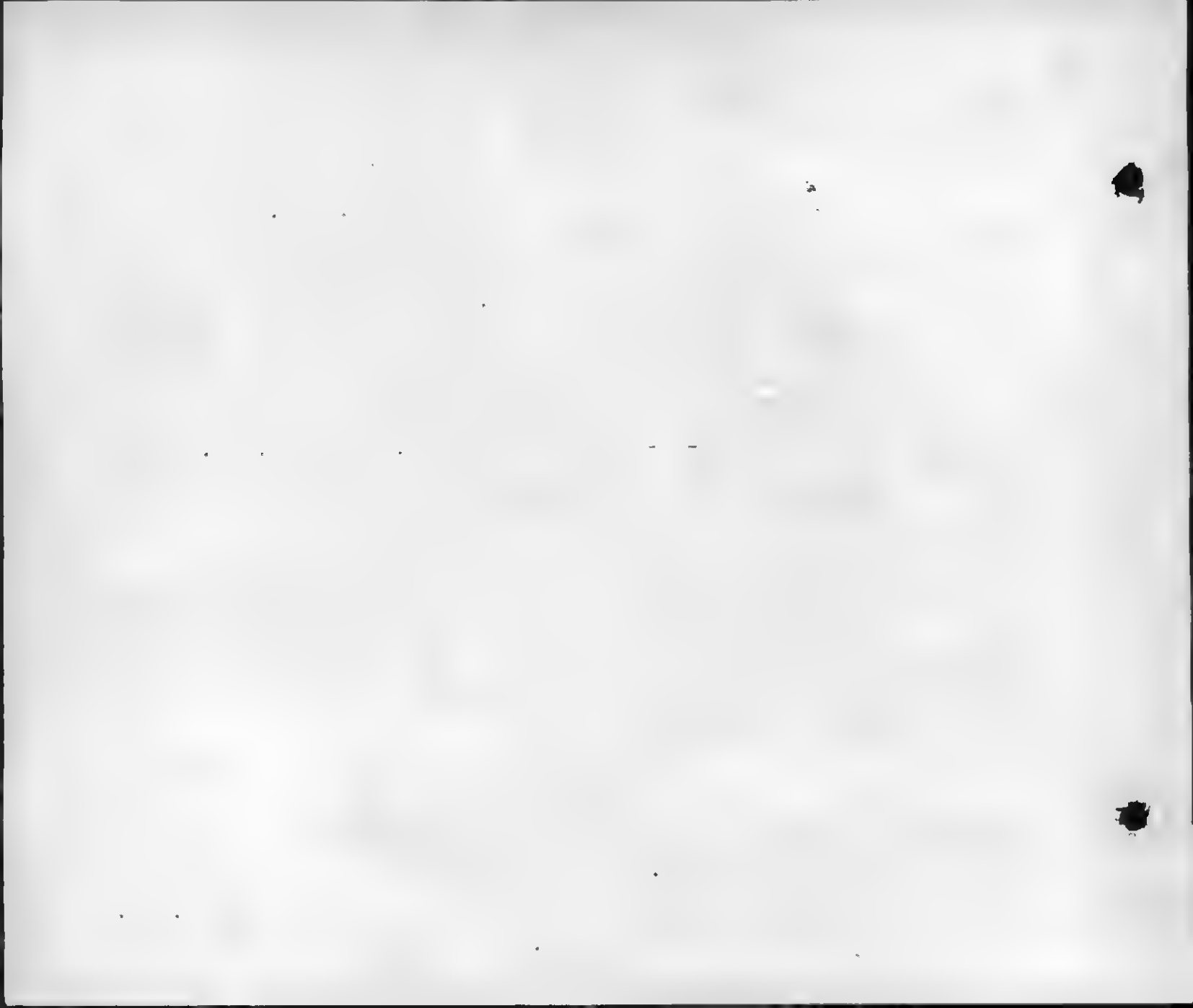
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		d. STREET ADDRESS Phillips St. Ext.	
3. NAME OF DECEASED (Type or print) Erma Hunter		4. DATE OF DEATH January 30 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1928
9. AGE (In years last birthday) 30 yrs		IF UNDER 1 YEAR: Months 30 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Hunter		14. MOTHER'S MAIDEN NAME Cora Beamon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 227-26-7879	
17. INFORMANT Cora Hunter, Suffolk, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Methyl alcohol poisoning			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
Hour ? a. m. ? p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ??	
20f. (City or town) ?		(County) ? (State) ?	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 2/6/59	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/59	
22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Dor. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE W. J. H. H.	

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



578

CERTIFICATE OF DEATH

00559

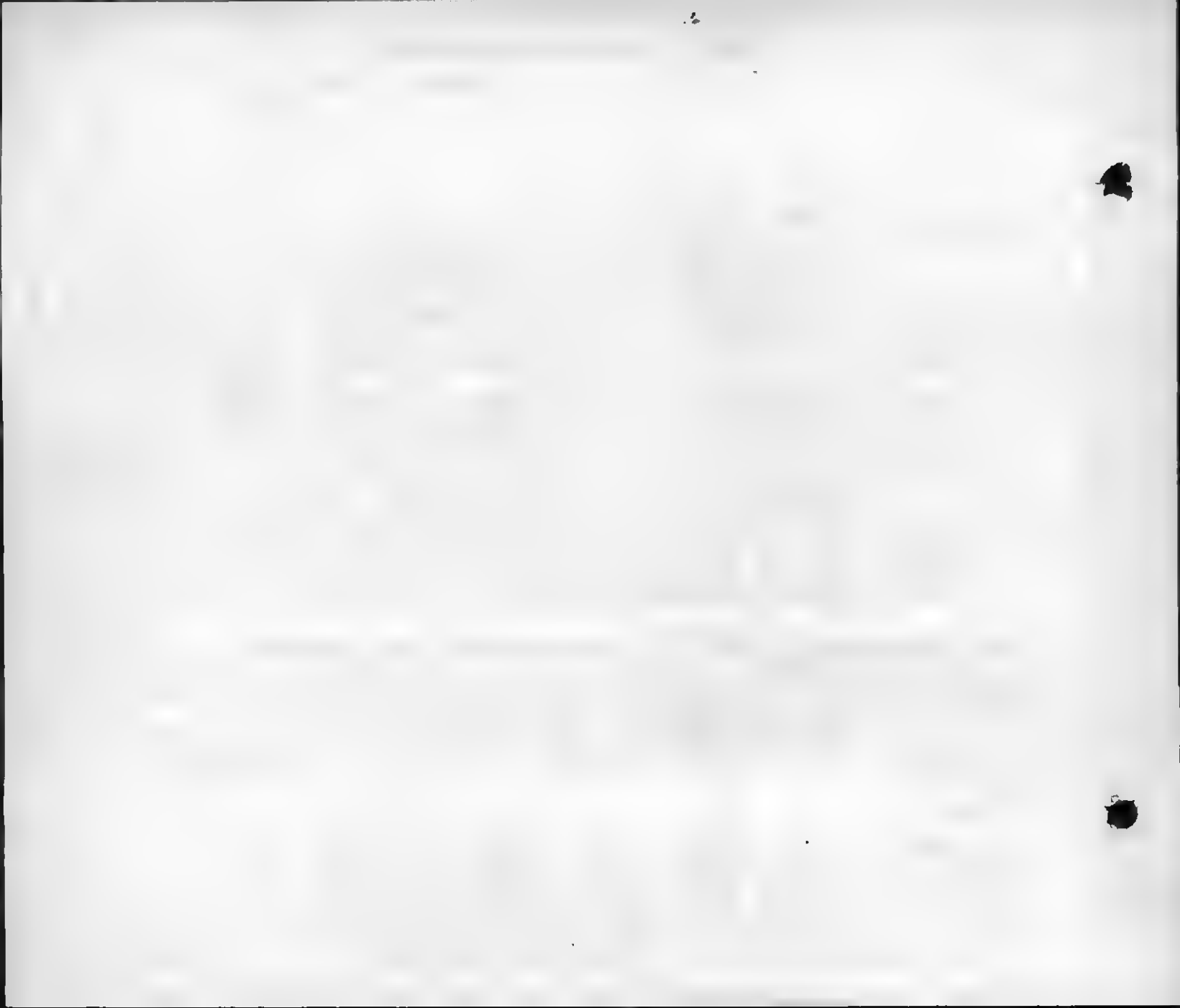
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Lecohester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Lecohester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Oba</u> Middle <u>Tucker</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. O. R. Jenkins, Secretary</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Scriptures Esophagus Varices</u> <u>591.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Portal Cirrhosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4/over</u> <u>10yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>58</u> , to <u>1/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>58</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold B. Phummer</u> M.D.		ADDRESS (Street, city or town, state) <u>Preston Maryland</u> DATE SIGNED <u>1/13/59</u>	
PHYSICIAN'S NAME (Type) <u>Harold B. Phummer</u>		<u>Preston Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich. S. Mulhobby</u> ADDRESS <u>East New Market, Md</u>		24. REC'D BY REGISTRAR <u>DATE</u> <u>5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>James E. Price</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

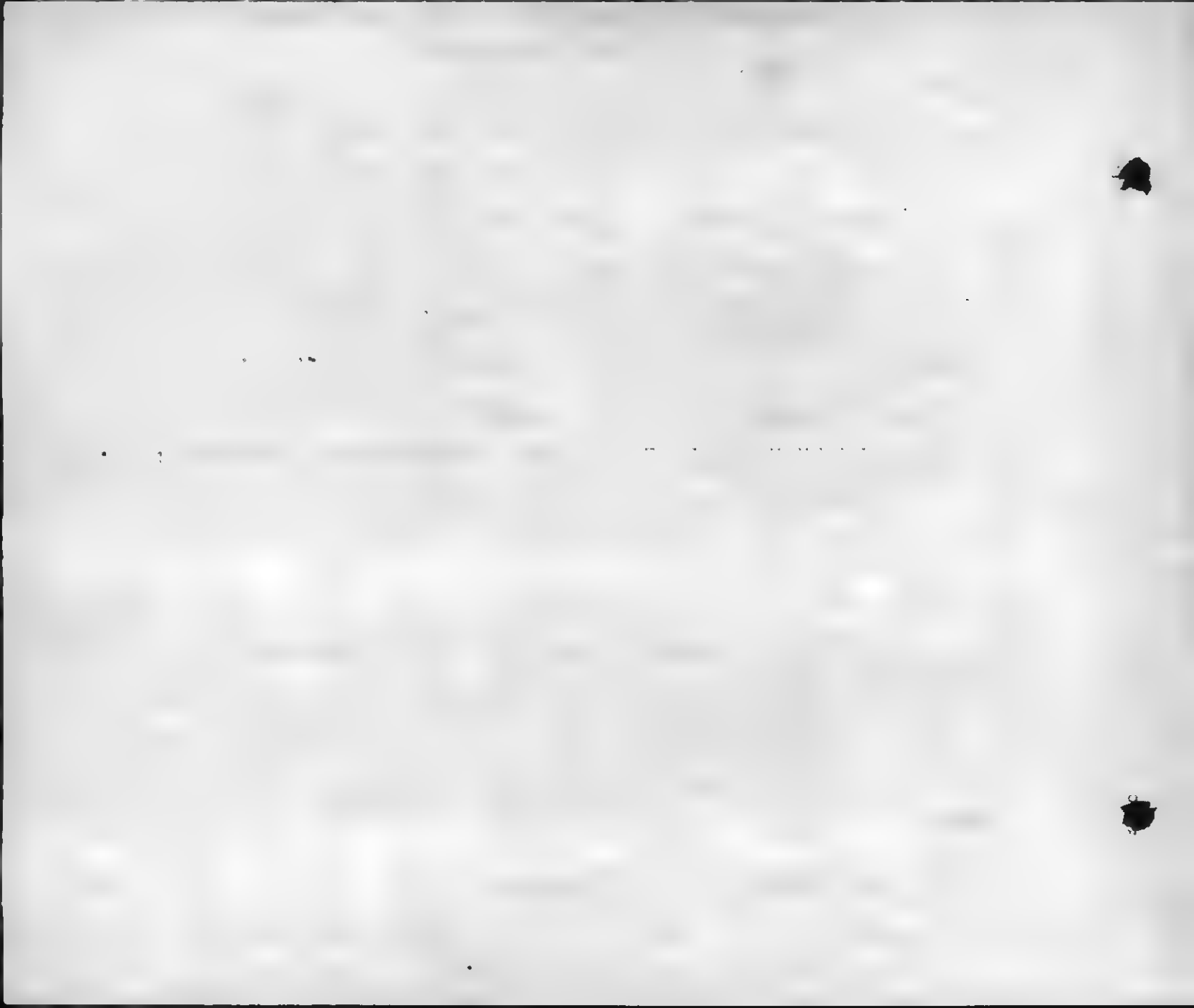
00560

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 Douglas Street</u>		d. STREET ADDRESS <u>65 Douglas Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Maryland</u> Last <u>Jews</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Jews</u>		14. MOTHER'S MAIDEN NAME <u>Annette Jews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-6406</u>	
17. INFORMANT <u>Matteriee Cornish, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>CARDIAC DECOMPENSATION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-31-1958</u> to <u>1-14-1959</u> that I last saw the deceased alive on <u>1-14-1959</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St - CAMB, Md - 1-1537</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>J. Edwin Fasset</u> PHYSICIAN'S NAME (Type) <u>J. EDWIN FASSETT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL-DIRECTOR'S SIGNATURE <u>Robert M. Solberg</u>		24a. REC'D BY REGISTRAR <u>DATE 20 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

579

CERTIFICATE OF DEATH

Reg. Dist. No.

00561

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS <div> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div>	
3. NAME OF DECEASED (Type or print) First Friederick Middle Johnson Last Johnson		4. DATE OF DEATH Month Jan Day 24 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	9. AGE (In years last birthday) 68 yrs <div> IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.: Months 0 Days 0 Hours 0 Min. 0 </div>
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnson		14. MOTHER'S MAIDEN NAME Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 1-0-0-000000	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 33ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ </div>		INTERVAL BETWEEN ONSET AND DEATH 20 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Cambridge		(County) Dorchester (State) Md.	
21. I certify that I attended the deceased from Jan 24, 1959 , to Jan 24, 1959 , that I last saw the deceased alive on Jan 24, 1959 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge		DATE SIGNED 1-24-59	
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.		Eastern Shore State Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-27-59	22c. NAME OF CEMETERY OR CREMATORY Greenwood	22d. LOCATION (City, town, or county) (State) Greenwood, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. H. H.		24. REGISTRAR'S SIGNATURE C. H. H. H.	
ADDRESS		DATE FEB 2 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



564 CERTIFICATE OF DEATH

Reg. Dist. No.

00562

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Park Lane		d. STREET ADDRESS 9 Park Lane	
3. NAME OF DECEASED (Type or print) First Margaret Middle Last Jones		4. DATE OF DEATH Month January Day 27 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aaron Manoky	
14. MOTHER'S MAIDEN NAME Annie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO None		17. INFORMANT Hynson Jones, 5 Hughes Street, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 2, 1959 , to January 27, 1959 , that I last saw the deceased alive on January 27, 1959 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md DATE SIGNED 1-31-59	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Thompsontown Cemetery	22d. LOCATION (City, town, or county) (State) Near East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR FEB 4 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

580

CERTIFICATE OF DEATH

00563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylors Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylors Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Millie</u> Middle <u>Keene</u> Last <u>Keene</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Keene</u>				14. MOTHER'S MAIDEN NAME <u>Amelia LeCompte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Rachel Bailey, Taylors Island, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuber-schwan disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1959</u> to <u>Jan 14, 1959</u> ; that I last saw the deceased alive on <u>Jan 14, 1959</u> , and that death occurred at <u>6:17</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>Jan 16, 1959</u>							
ACTUAL SIGNATURE <u>James H. Thompson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Thompson, James H.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. [Signature]</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



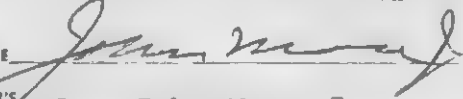
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00564

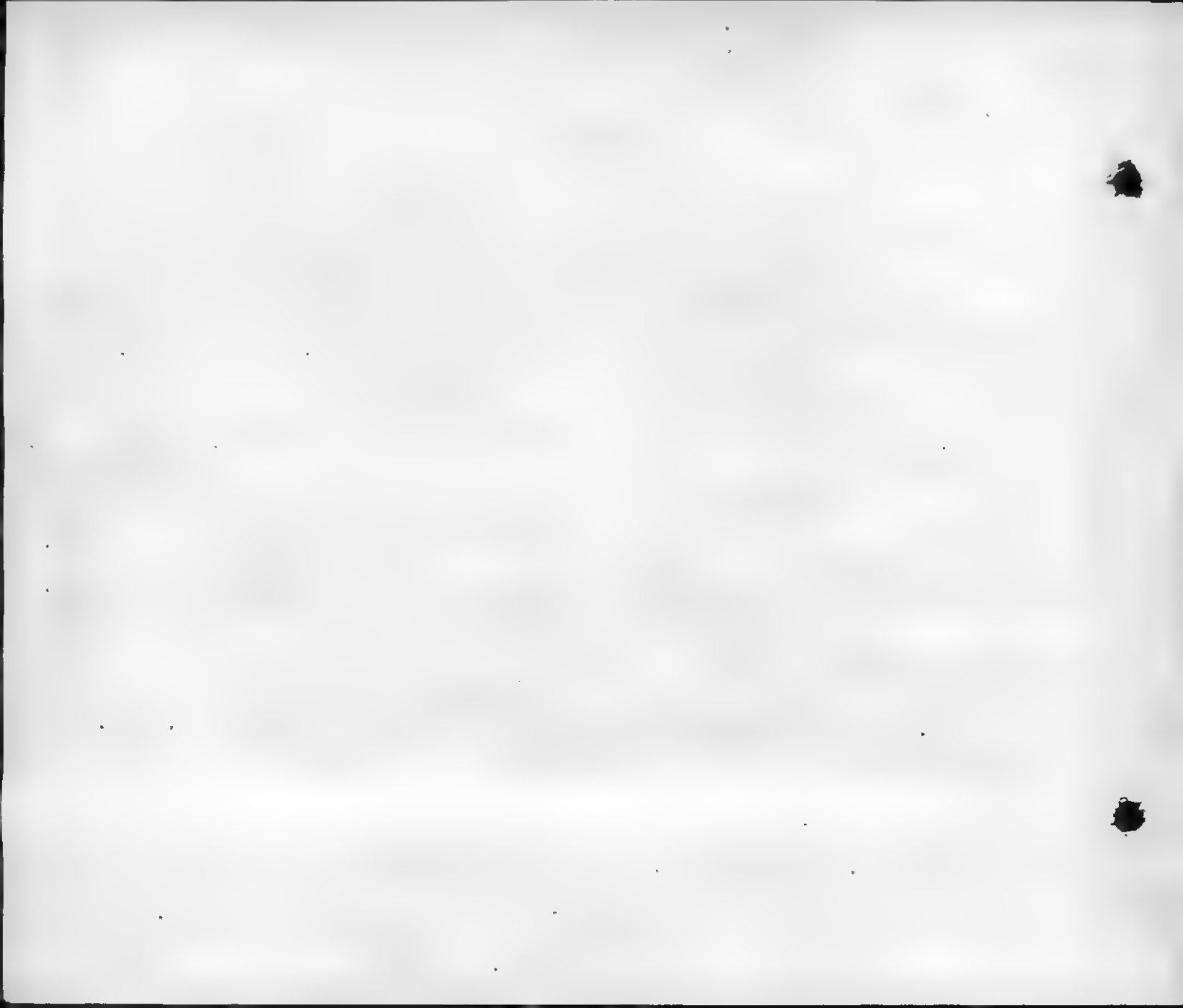
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 42 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glasgow Convalescent Home		d. STREET ADDRESS 409 Byrn Street	
3. NAME OF DECEASED (Type or print) Louise Saunders Lake		4. DATE OF DEATH January 18, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1865
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cecil County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Saunders		14. MOTHER'S MAIDEN NAME Martha Hanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Howard Weedon, 409 Byrn St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BET. LAST ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Terminal Bronchopneumonia		4 days	
DUE TO Arteriosclerotic cardio vascular renal disease		15 yrs.	
DUE TO Arteriosclerosis, generalized		15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Fracture neck left femur			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in bath room.	
20c. TIME OF INJURY Month, Day, Year 8 Am. o. m. 10/26 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cambridge, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE FEB 4 '59		24b. REGISTRAR'S SIGNATURE 2478 Grand	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



581 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>7yr 8mo 14days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. STREET ADDRESS <u>Secretary</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Lauck</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1959</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 8, 1872</u>		9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Lauck</u>				14. MOTHER'S MAIDEN NAME <u>Tilly Seigfried</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>RECORDS: Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>--</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>January 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 12</u> , 19 <u>59</u> , and that death occurred at <u>2:45A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u> DATE SIGNED <u>1-13-59</u>							
ACTUAL SIGNATURE <u>Ettore DeFilippis</u>				M.D. <u>Cambridge, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Ettore DeFilippis</u>				Eastern Shore State Hospital, Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/15/59</u>		<u>East New Market</u>		<u>East New Market, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank S. Hurloughby</u>				ADDRESS <u>East New Market</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 1959</u>	
						24b. REGISTRAR'S SIGNATURE <u>S. Hurloughby</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00568

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write nearest town) Cambridge (Rural)		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. Maryland b. COUNTY Dorchester	
c. LENGTH OF STAY IN Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R F D # 3 Cambridge		d. STREET ADDRESS R F D # 3 Cambridge	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John V. Lewis		4. DATE OF DEATH Jan 9 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 31 1907
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME T Hicks Lewis		14. MOTHER'S MAIDEN NAME Mahie Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Naomi Lewis		Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-12 , 19 56 , to 1-9 , 19 59 , that I last saw the deceased alive on 12-59 , 19 59 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Bannan M.D.		ADDRESS (Street, city or town, state) Cambridge DATE SIGNED 1-10-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Maryland.	
24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE	



566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D.		c. LENGTH OF STAY IN TB 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Beatrice Last McNaughton		4. DATE OF DEATH Month Jan. Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Cambridge	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert F. Spear		14. MOTHER'S MAIDEN NAME Mary Francis Goslin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. John McNaughton, Cambridge, Md. R.D. 2	
17. INFORMANT John McNaughton, Cambridge, Md. R.D. 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction of small intestine 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Mesenteric thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1958 to Jan. 3, 1959 , that I last saw the deceased alive on Jan. 2, 1959 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Lewis M. Burdette M.D. 1 Locust St.		Jan 3, 1959	
PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery	22d. LOCATION (City, town, or county) (State) East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth A. Shovier		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE JAN 7 59		24b. REGISTRAR'S SIGNATURE Wm. S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



583

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nathaniel Middle Warthman Last Medford				4. DATE OF DEATH Month January Day 17 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY House Carpenter		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Medford				14. MOTHER'S MAIDEN NAME Sallie Harper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 168-16-7422		17. INFORMANT Leon W. Medford, Hurlock, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastases DUE TO Carcinoma apex right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inoperable DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis - Bilateral deafness						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 47 , to 1-17 , 19 59 that I last saw the deceased alive on 1-15 , 19 59 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Harry B. Plummer M.D.				PHYSICIAN'S NAME (Type) Dr. H. B. Plummer Preston Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 2 6 '59		24b. REGISTRAR'S SIGNATURE C. L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No.

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00570

585

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Indiantown Road						d. STREET ADDRESS Indiantown Road					
3. NAME OF DECEASED (Type or print)		First Calvin		Middle Edward		Last Milligan		4. DATE OF DEATH Month January		Day 6	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1913		9. AGE (in years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J. Frank Milligan		14. MOTHER'S MAIDEN NAME Sallie Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-48-J160		17. INFORMANT Mrs. Sallie M. Fritzsche		Address Easton, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns face, head, arms legs. 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 916.0 DUE TO (c) 916.0		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) In home which burned.									
20c. TIME OF INJURY Month, Day, Year 4 P.M. 1/6/ 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Vienna,		(County) Dor.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Maco Jr.</i>		EXAMINER'S NAME (Type) Dr. John Maco Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/10/59	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY McKendree Cemetery		22d. LOCATION (City, town, or county) Near Rhodesdale, Maryland		22e. (State) Md.		22f. (County) Dor.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR JAN 1 1959		24b. REGISTRAR'S SIGNATURE <i>John Maco Jr.</i>		24c. (City, town, or county) Federalsburg, Maryland	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



00571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Bessie		Middle Whittington		Last Moore	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1880	
9. AGE (In years last birthday) 78 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Near Dover, Del.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Thomas Whittington				14. MOTHER'S MAIDEN NAME Emma Melvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Dwight L. Moore, Williamsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of DUE TO (c) gall-bladder						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan 20 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 2, 1958 to Jan 20, 1959 , that I last saw the deceased alive on Jan 19, 1959 , and that death occurred at 1:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis M. Burdette		ADDRESS (Street, city or town, state) 1 Locust St. Cambridge, Md.					
PHYSICIAN'S NAME (Type) Lewis M. Burdette		DATE SIGNED Jan 23 '59					
22a. BURIAL, CREMATATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Remond R. Thow				24a. REC'D BY REGISTRAR Jan 23 '59		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

586 CERTIFICATE OF DEATH

00572

Reg. Dist. No.

1. PLACE OF DEATH a. Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res. den. before admiss. on) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford				c. LENGTH OF STAY IN 1b 9 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woolford				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter J Moxom				4. DATE OF DEATH Month Jan Day 13 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1885	9. AGE (In years lost birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meteorologist Ret.				10b. KIND OF BUSINESS OR INDUSTRY U S Weather Dept.		11. BIRTHPLACE (State or foreign country) Missouri	
13. FATHER'S NAME Joseph Moxom				14. MOTHER'S MAIDEN NAME Lurinda Duckworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Walter Moxom Woolford Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY DECOMPENSATION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos 3 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Oct 13 , 19 58 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 12 , 19 59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 RACE ST CAMBRIDGE MD. DATE SIGNED 1/14/59							
ACTUAL SIGNATURE Alfred R. Maryanov M.D.		PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV CAMBRIDGE MD.					
22a. BURIAL, CREMATION, or other disposition Cremation	22b. DATE THEREOF Jan 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			ADDRESS Cambridge Maryland	24a. REC'D BY REGISTRAR DATE JAN 19 '59	24b. REGISTRAR'S SIGNATURE Col. J. H. Hume		



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CERTIFICATE OF DEATH

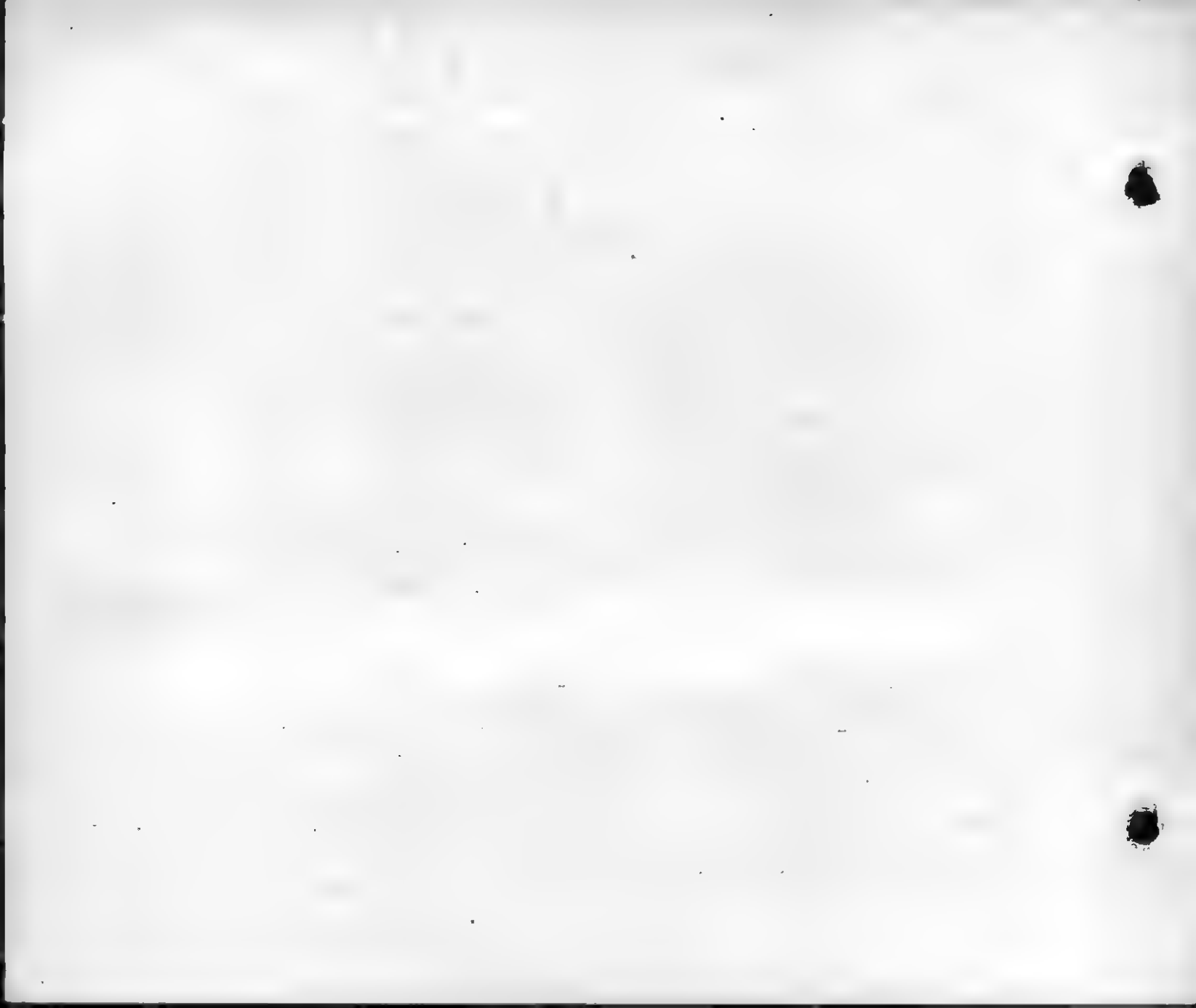
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorchester Cambridge				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) Belvedere Ave				e. STREET ADDRESS 206 Belvedere Ave			
3. NAME OF DECEASED (Type or print) Annie S. Palmer				4. DATE OF DEATH Month Jan Day 6 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 6, 1865	9. AGE (In years last birthday) yrs 93	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Stevens				14. MOTHER'S MAIDEN NAME Elizaberth Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT Edith Love Cambridge Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic hypertensive cardio vascular DUE TO (c) Arteriosclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years+ 3 years+	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year -- -- -- 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --	
				20f. (City or town) -- -- --		(County) -- -- --	
						(State) -- -- --	
21. I certify that I attended the deceased from 3-6-57 , 19__, to 1-6-59 , 19__, that I last saw the deceased alive on 1-6-59 , 19__, and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 1-7-59							
ACTUAL SIGNATURE Eldridge H. Wolff				M.D. 15 Locust Street, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 8, 1959		22c. NAME OF CEMETERY OR CREMATORY East New Market Cem.		22d. LOCATION (City, town, or county) (State) East New Market Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR JAN 12 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 Study. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57

569

CERTIFICATE OF DEATH

Reg. Dist. No.

00574

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN TB 1 hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hosp,		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 320 West End Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle S Last Price		4. DATE OF DEATH Month Jan Day 17 , Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1896
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas S Price Sr.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give branch or dates of service) Army		16. SOCIAL SECURITY NO 220 16 7634	
17. INFORMANT William S Price Jr.		Address Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RECURRENT RHEUMATIC FEVER 400X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UPPER RESPIRATORY DISEASE DUE TO (c) 10 DAYS 10 DAYS		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/29 , 19 55 , to 17 JAN , 19 59 , that I last saw the deceased alive on 16 JAN , 19 59 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above.			
ACTING SIGNATURE Walter E. Gunby Jr		ADDRESS (Street, city or town, state) 105 CHURCH ST	
DATE SIGNED 21 JAN 59			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR		CAMBRIDGE MD.	
22a. BURIAL, CREMATION, or other disposition Burial	22b. DATE THEREOF Jan 19 1959	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cem.	22d. LOCATION (City, town, or county) (State) Cambridge Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Maryland	
24a. REC'D BY REGISTRAR JAN 23 '59		24b. REGISTRAR'S SIGNATURE Charles P. K...	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOZMAN MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Nursing Home		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First LILLIE Middle B. Last RICHARDSON		4. DATE OF DEATH Month JAN Day 31 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28 1874
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) BOZMAN MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT MCQUAY		14. MOTHER'S MAIDEN NAME Josephine James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard T. Richardson		Address Bozman Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac degeneration (Chronic) DUE TO 4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO 7 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 wks 7
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/24 , 1959, to 1/31 , 1959, that I last saw the deceased alive on 1/24 , 1959, and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Larry B. Panman		ADDRESS (Street, city or town, state) P.O. Box 158 Bozman Md	
PHYSICIAN'S NAME (Type) Howard B. Panman		DATE SIGNED Feb 11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 3, 1959	22c. NAME OF CEMETERY OR CREMATORY BOZMAN CEMETERY	22d. LOCATION (City, town, or county) (State) Bozman Md
23. FUNERAL DIRECTOR'S SIGNATURE S. Hankerton Harrison		ADDRESS P. Michaels	
24a. REC'D BY REGISTRAR DATE FEB 3 '59		24b. REGISTRAR'S SIGNATURE —	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



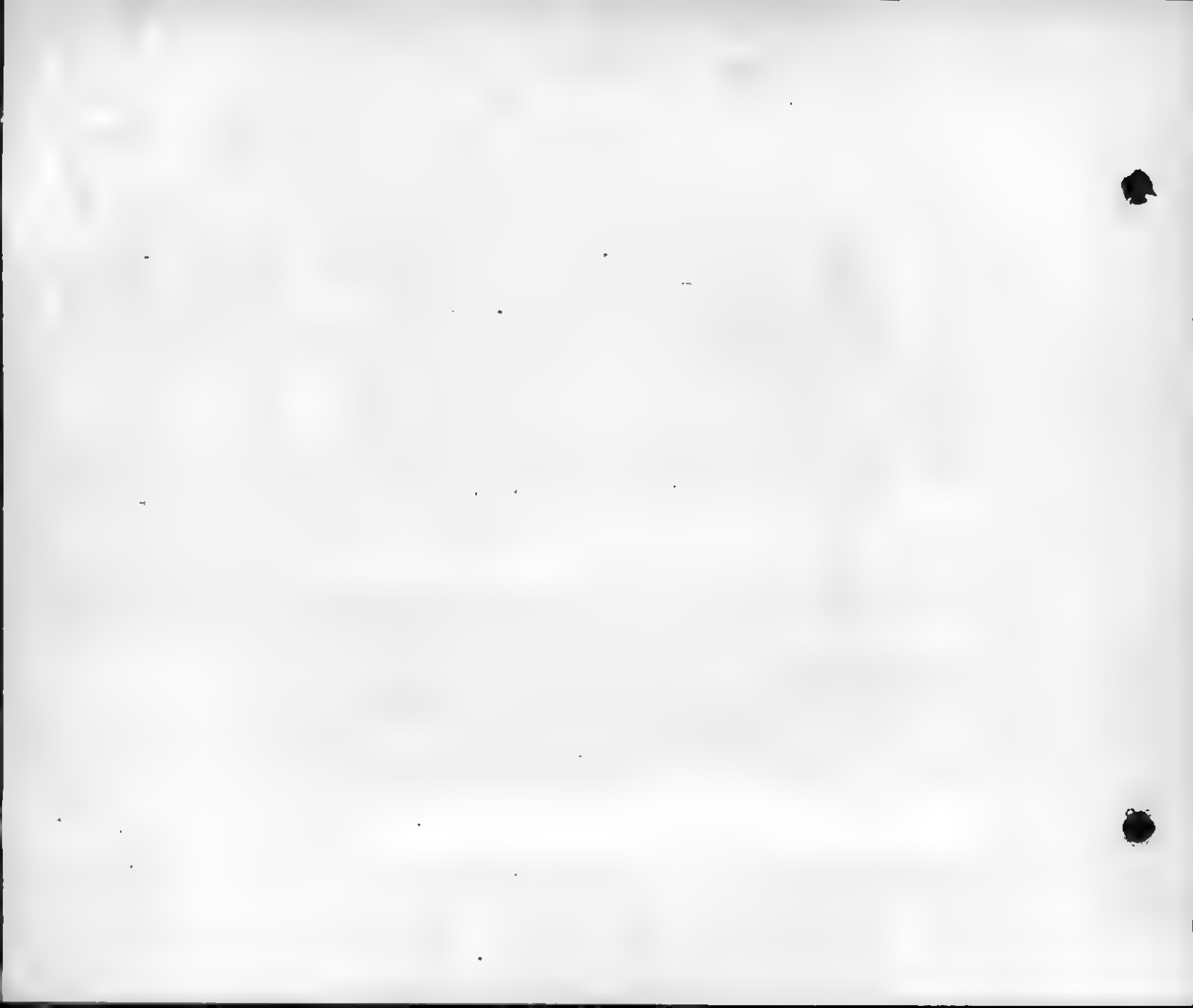
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) Cambridge Maryland Hosp.		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ira Middle D. Last Sanders		4. DATE OF DEATH Month Jan Day 11 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1892	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months 11 Days 19 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feed Mill		10b. KIND OF BUSINESS OR INDUSTRY Made Feed		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William D Sanders		14. MOTHER'S MAIDEN NAME Sarah Tregoe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 218 16 6727		
17. INFORMANT Mrs Perry North		Address Cambridge Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 28 APRIL, 1952 , to 11 JAN, 1959 , that I last saw the deceased alive on 10 JAN, 1959 , and that death occurred at 7:05 A , from the causes and on the date stated above. ACTUAL SIGNATURE Walter E. Gunby Jr. M.D. ADDRESS (Street, city or town, state) 105 Church St. - 12 JAN 59 DATE SIGNED PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. Cambridge Md.				
22a. BURIAL, CREMATION, REMOVA (Specify) Burial	22b. DATE THEREOF Jan 13, 1959	22c. NAME OF CEMETERY OR CREMATORY Jeppa Cemetery	22d. LOCATION (City, town, or county) (State) Madison Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Maryland.		
24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE William S. F. and		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

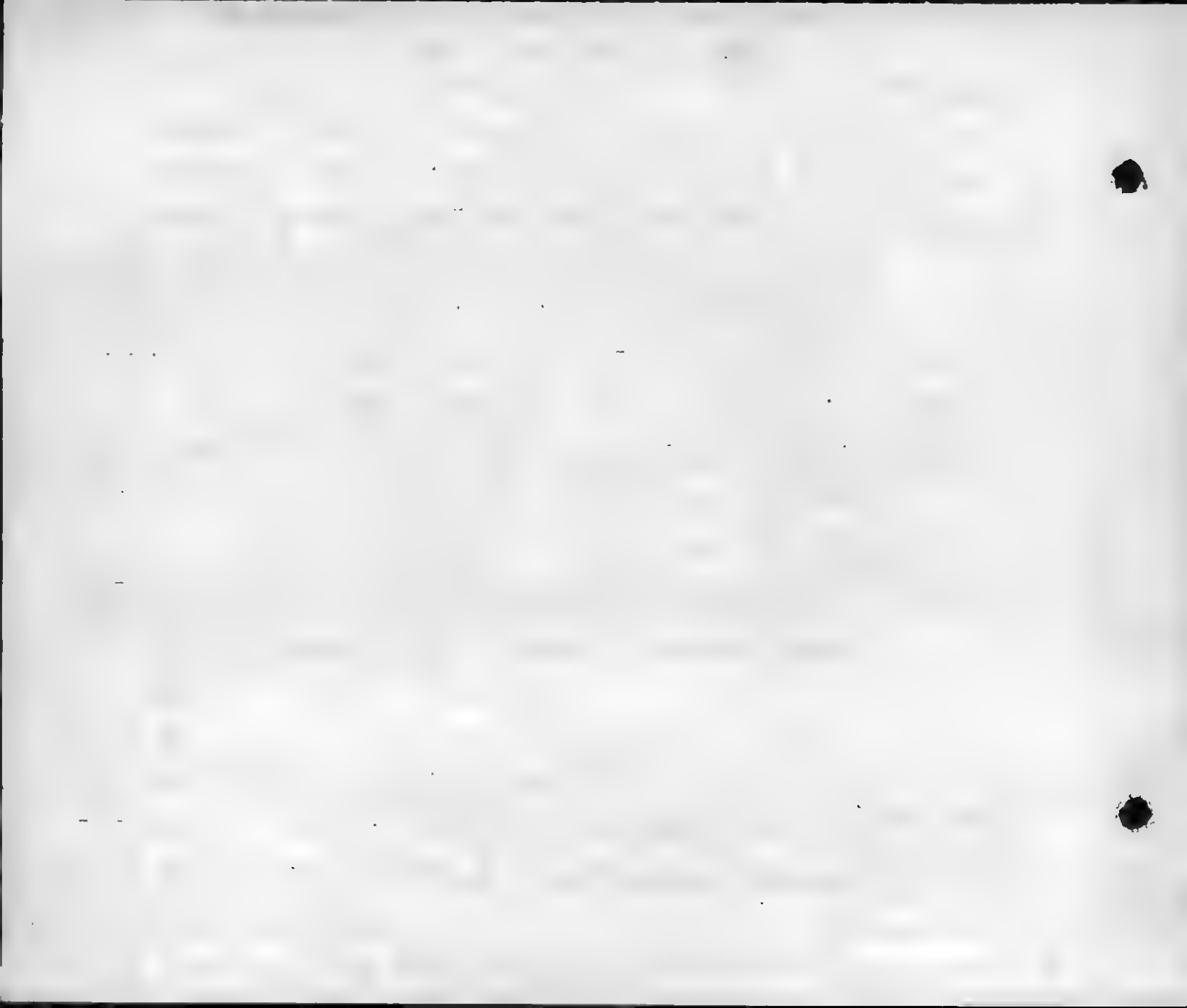
589

CERTIFICATE OF DEATH

00578

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>1yr 2mo 5days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>			d. STREET ADDRESS <u>-</u>		
3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Spedden</u> Last <u>Seymour</u>			4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 10, 1884</u>	9 AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>19</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William H. Seymour</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Clarissa Marshall</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT Address <u>RECORDS: Eastern Shore State Hospital</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 7, 1957</u> , to <u>January 12, 1959</u> , that I last saw the deceased alive on <u>January 12, 1959</u> , and that death occurred at <u>8:55 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ettore DeFilippis</u> M.D.			ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u>		
DATE SIGNED <u>1-13-59</u>					
PHYSICIAN'S NAME (Type) <u>Ettore DeFilippis</u> Eastern Shore State Hospital, Cambridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>			ADDRESS <u>St. Michaels</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>
			24b. REGISTRAR'S SIGNATURE		



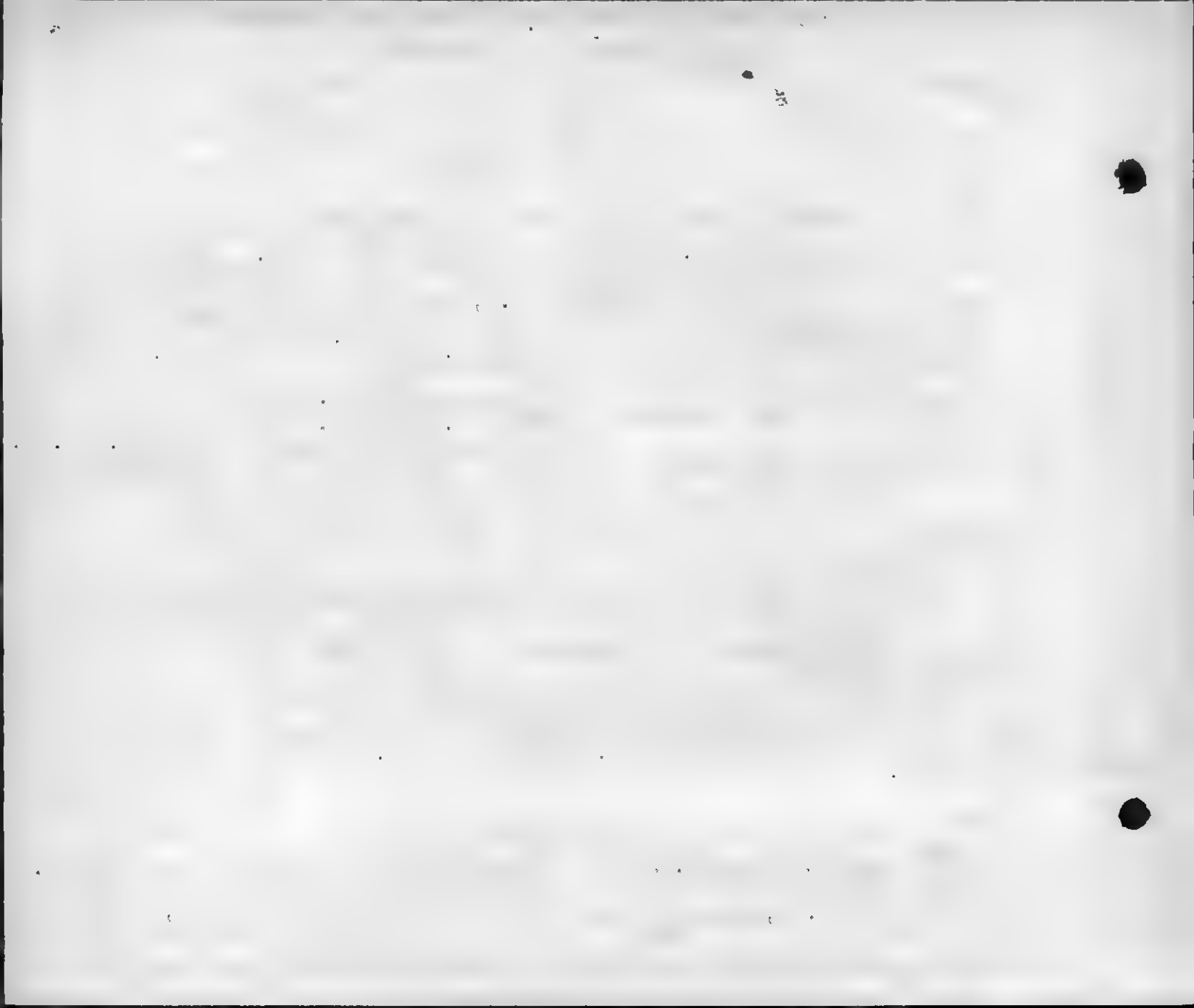
588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury,</u>			
c. LENGTH OF STAY IN 1b <u>9 days</u>				d. STREET ADDRESS <u>213 Washington St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE F. (GLADDEN) SHORES</u>				4. DATE OF DEATH Month Day Year <u>Jan. 21 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>2 20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dames Quarter, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Samuel T. Gladden</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Gladden T. Shreves</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Mrs. Marion K. Smith (Daughter) 213 Wash St. Sal. Md.</u> (Eastern Shore State Hospital records)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan. 12, 1959</u> , to <u>Jan. 21, 1959</u> , that I last saw the deceased alive on <u>Jan. 21, 1959</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
ACTUAL PHYSICIAN <u>Thomas J. Dredge, M.D.</u>				ADDRESS (Street, city or town, state) <u>F.S.S. - Cambridge Md</u> DATE SIGNED <u>1/21/59</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>				Western Shore State Hospital, Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dames Quarter Cemetery-</u>		22d. LOCATION (City, town, or county) (State) <u>Dames Quarter, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the medical director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00579	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If inst. of residence before admission) a. STATE Maryland b. COUNTY Dorchester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN TB 18 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Edgewood Ave.					d. STREET ADDRESS					IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marjorie Smith					4. DATE OF DEATH Month January Day 7 Year 1959						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1/1914		9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months 44 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lorenzo Griffen					14. MOTHER'S MAIDEN NAME Sarah Tilghman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Frank Smith Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Methyl-alcohol-poisoning- 8x0.4 DUE TO Acute methanol poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) ?										INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Apparently drank methyl alcohol						
20c. TIME OF INJURY Month, Day, Year Hour unknown a.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown		20f. (City or town) unknown		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Mace Jr.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					1/ 22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/11/59		22c. NAME OF CEMETERY OR CREMATORY Carmichael Cemetery			22d. LOCATION (City, town, or county) (State) Queen Anne, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair					ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 2 6 '59		24b. REGISTRAR'S SIGNATURE ...		



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Ken.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b over 1 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterton		d. STREET ADDRESS Washington Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Harrison Harrison		4. DATE OF DEATH Month Day Year Jan 24 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Evans		14. MOTHER'S MAIDEN NAME Sarah Ralph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 110	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 1191 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH unk
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from June 5, 1956, to Jan 24, 1959 , that I last saw the deceased alive on Jan 24, 1959 , and that death occurred at 1:24 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge M.D. Eastern Shore State Hospital, Cambridge, Md.		DATE SIGNED 1-24-59	
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.		Eastern Shore State Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Jan. 26, 1959	22c. NAME OF CEMETERY OR CREMATORY CHESTER	22d. LOCATION (City, town, or county) (State) CHESTERTOWN, Md
23. FUNERAL DIRECTOR'S SIGNATURE John W. Wells		ADDRESS Chesterton, Md.	24a. REC'D BY REGISTRAR JAN 27 '59
24b. REGISTRAR'S SIGNATURE C. W. & F. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		d. STREET ADDRESS <u>R. F. D. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAMBRIDGE Adv. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>ANN</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1958</u>		9. AGE (In years last birthday) yrs <u>9</u> Months <u>15</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Josiah Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Kirgie Willis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Kirgie Willis</u> Address <u>EAST-NEW MARKET Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastroenteritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/24/59</u> , 19 <u>59</u> , to <u>1/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>59</u> , and that death occurred at <u>3:08 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St Cambridge, Md.</u> DATE SIGNED <u>1/27/59</u>							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov, M.D.</u>				<u>Cambridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-27-59</u>		<u>Bucktown Md.</u>		<u>Dorchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. J. S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



591

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN 1b 53 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broad Street				/ d. STREET ADDRESS Broad Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Effie Middle May Last Willson				4. DATE OF DEATH Month Jan Day 21 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours 15 Min.		IF UNDER 24 HRS. Months 7 Days 5 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Patrick H. Wright				14. MOTHER'S MAIDEN NAME Mary Ellen Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Address J. Walter Willson, Sr. Hurlock, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous							1 mo.
157X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma head of Pancreas							6 mos. ?
DUE TO (c) Arteriosclerotic Heart Disease							15 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-28, 1958 , to 1-21, 1959 ; that I last saw the deceased alive on 1-21, 1959 , and that death occurred at 12 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 126 Bloomingdale Avenue DATE SIGNED							
ACTUAL SIGNATURE H. R. Trammell M.D. Federalburg, Maryland							
PHYSICIAN'S NAME (Type) H. R. Trammell, M.D. Federalburg, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold Williams - Federalburg, Md.				ADDRESS		24a. REC'D BY REGISTRAR JAN 28 59 DATE	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00583

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kim Norlene Woolford		4. DATE OF DEATH Month January Day 8 Year 19 59 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/58
9. AGE (In years last birthday) yrs. 3 Months 23 Days 		10. IF UNDER 1 YEAR Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY None	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Woolford		14. MOTHER'S MAIDEN NAME Mildred Chester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Silas Woolford		Address 15 Maces Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/59	
22c. NAME OF CEMETERY OR CREMATORY Hugh's Mission Cem.		22d. LOCATION (City, town, or county) (State) Cambridge, Dorchester, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JAN 13 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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